

11390 CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Snow Hill</i>	LENGTH OF STAY (in this place) <i>74 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Snow Hill</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Edward</i> (Middle) <i>Allen</i> (Last) <i>Allen</i>		DATE OF DEATH: <i>Nov. 29 1965</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>Caucasian</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Aug. 9-1881</i>
9. AGE last birthday <i>74 yrs.</i>		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i></i>	
11. BIRTHPLACE (State or foreign country): <i>Snow Hill, md</i>		12. CITIZEN OF WHAT COUNTRY? <i></i>	
13. FATHER'S NAME: <i>Sidney Allen</i>		14. MOTHER'S MAIDEN NAME: <i>Ellen Armstrong</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) <i>Yes</i> Give war or dates of service <i>70</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Helene Allen, Snow Hill, md</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Toxemia</i>			<i>12 Hr.</i>
DUE TO			
ANTECEDENT CAUSE (B) <i>Lobar Pneumonia</i>			<i>1 wk</i>
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <i>Myocardial Insufficiency</i>			<i>1 yr.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov. 25, 1955</i> , to <i>Nov. 29, 1965</i> that I last saw the deceased alive on <i>Nov. 28, 1955</i> , and that death occurred at <i>8:15 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Robert L. LaMar</i>		DATE SIGNED <i>11/29/55</i>	
23. MARRIAGE, CREMATION, DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
REMOVAL (SPECIFY) <i>Dec 3/65</i>		<i>Cheney Methodist</i>	
DATE REC'D BY LOCAL REGISTRAR <i>11/30/55</i>		REGISTRAR'S SIGNATURE <i>Clayton E. Cooper</i>	
FUNERAL DIRECTOR		ADDRESS <i>Clayton E. Cooper, Snow Hill, md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11391

12535

Reg. Dist.

No. 351

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>W.D.</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY OR (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Snow Hill</u>				TOWN <u>Snow Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) <u>Sarah</u> (Middle) <u>A.</u> (Last) <u>Bowen</u>				4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Dec. 15 1895</u>	
9. AGE last birthday: <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Snow Hill Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <u>Isaac Bowen</u>				14. MOTHER'S MAIDEN NAME: <u>Lucile Pettit</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>W.D. George W. Bowen, 7931 Robert Rd, Norfolk 3, Va.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Acute Coronary Occlusion</u>				<u>minutes</u>	
Antecedent cause(s)		(b) <u>DUE TO</u>					
Diseases or conditions, if any, giving rise to the above cause		(c) <u>DUE TO</u>					
stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
						(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Edmund L. Mar</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-1-55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL/CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Snow Hill Baptist</u>		LOCATION (City, town or county) <u>Snow Hill, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Dec 3, 55</u>		REGISTRAR'S SIGNATURE <u>Clayton E. Cooper</u>		24. FUNERAL DIRECTOR <u>Clayton E. Cooper, Snow Hill, Md.</u>			

BUREAU V. S.

DEC 20 1925

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11398

11398 CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WORCESTER</u>		MARYLAND		STATE <u>MO</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL OR TOWN) <u>OCEAN CITY</u>		LENGTH OF STAY (in this place) <u>50 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>OCEAN CITY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore Ave</u>				STREET ADDRESS (If rural give location) <u>BALTIMORE AVE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>SAVANNAH DENNIS CAREY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>NOV. 8 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>AUG. 15 1883</u>	9. AGE last birthday: <u>72 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOTEL MANAGER</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOTEL</u>		11. BIRTHPLACE (State or foreign country): <u>NEWARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME: <u>REVERDY J. DENNIS</u>				14. MOTHER'S MAIDEN NAME: <u>ELLA E. PHILLIPS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>No</u>		17. INFORMANT & ADDRESS: <u>MR. EDW. LEG CAREY, OCEAN CITY, MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH:	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u> <u>CORONARY OCCLUSION MASSIVE</u>						<u>10 minutes</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cvd</u>						<u>84 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Obesity</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 7, 1955</u> , to <u>Nov 8, 1955</u> , that I last saw the deceased alive on <u>Nov 7, 1955</u> , and that death occurred at <u>1:05</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Ocean City, Md</u>		DATE SIGNED <u>Nov 10, 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-12-55</u>		REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>		24. FUNERAL DIRECTOR <u>Anna A. Burboze</u>		ADDRESS <u>Berlin Md</u>	

BUREAU V. F.

NOV 16 1955

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(Letter signed, copy)
Colonel Robinson

Mr. E. F. Casey, General
Lt. E. F. Casey

Copy

11393 CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Harcester</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Harcester</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Whaleyville</i>	LENGTH OF STAY (in this place) <i>20 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Whaleyville Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
First (Middle) (Last) <i>Ida Morganett Cross</i>		OF DEATH: <i>Nov. 10 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>	8. DATE OF BIRTH: <i>Jan 15 1872</i>
9. AGE last birthday: <i>83</i> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housework</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own home</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Kingdy Williams</i>		14. MOTHER'S MAIDEN NAME: <i>Cordelia Hamblin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS: <i>Mrs Chas. Clark Accor City Md</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <i>Coronary Artery Disease</i>			<i>2 mos.</i>
ANTECEDENT CAUSE (B) <i>Chronic Cardiac failure</i>			<i>3 years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Atherosclerosis & Hypertension</i>			<i>10 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>Nov.</i> , 19 <i>53</i> , to <i>Nov.</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Nov.</i> , 19 <i>55</i> , and that death occurred at <i>Berlin, Md.</i> from the causes and on the date stated above.			
SIGNATURE <i>Robert A. Grubb MD</i>		DATE SIGNED <i>11/12/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<i>Burial</i>		<i>Willordy Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>11-12-55</i>		REGISTRAR'S SIGNATURE <i>Helen F. Hayward</i>	

MARGIN RESERVED FOR BINDER

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 16 1955

RECEIVED

DEC 20 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11400

11329
CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	LENGTH OF STAY (in this place) <u>40 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City Md</u>	
TOWN <u>Pocomoke</u>		TOWN <u>Pocomoke City Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>436 Bank St</u>		STREET ADDRESS (If rural, give location) <u>436 Bank St</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Celia</u>	(Middle) <u>Juster</u>	(Last) <u>11-13-1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>May 30-1891</u>
		9. AGE last birthday <u>64</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife at home</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>Pa</u>		12. CITIZEN OR WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Calvin Evans</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Justice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or M.K.): <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT & ADDRESS: <u>Else Gandy daughter</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>450.1</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Gangrene of foot</u>			<u>6 weeks</u>
(B) <u>Arteriosclerosis</u>			<u>D.K.</u>
(C) <u>Hypertension</u>			<u>D.K.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 13, 1915</u> , to <u>Nov 13, 1955</u> that I last saw the deceased alive <u>Nov 12, 1955</u> and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>M. E. Sartorius</u>		ADDRESS <u>Pocomoke City Md</u> DATE SIGNED <u>11/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-17-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>		LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>	
24. FUNERAL DIRECTOR <u>Edgar W. Winton</u>		ADDRESS <u>New Church, Va.</u>	



11395

12541

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 351

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill</u>	LENGTH OF STAY (in this place) <u>26 yrs</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Snow Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
<u>Lila</u> (First) <u>Maie</u> (Middle) <u>Harmon</u> (Last)		<u>11</u> (Month) <u>26</u> (Day) <u>1955</u> (Year)	
5. SEX: <u>2</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>4/7/1929</u>
9. AGE last birthday: <u>26</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. FATHER'S NAME: <u>Henry Dale</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. MOTHER'S MAIDEN NAME: <u>Edna Harmon</u>		14. MOTHER'S MAIDEN NAME: <u>Edna Baine - Snow Hill, MD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>(?)</u>	
17. INFORMANT & ADDRESS: <u>Edna Baine - Snow Hill, MD</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		<u>minutes</u>	
Immediate cause (a)..... DUE TO <u>Broken neck - also other injuries</u>			
Antecedent cause(s) (b)..... DUE TO <u>Auto-accident</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... <u>"Drunk" driver</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>11-26-55</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office, etc.) OF INJURY: <u>4 1/2 miles S of Worcester, MD</u>	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>11-26-55 1:15 PM</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>While out driving</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>N. E. Artorius</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/27/55</u>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
REMOVAL (Specify): <u>10/29/55</u>		<u>W. H. Niles</u>	
DATE RECD BY LOCAL REG. <u>11/30/55</u>		REGISTER'S SIGNATURE <u>W. H. Niles</u>	
		FUNERAL DIRECTOR <u>W. H. Niles</u>	
		ADDRESS <u>Snow Hill, MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

11396 CERTIFICATE OF DEATH

Reg. Dist. No. 351.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Montgomery</i>	
X CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		LENGTH OF STAY (in this place) <i>93 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
3. NAME OF DECEASED: (First) <i>Winona</i> (Middle) <i>C.</i> (Last) <i>Harris</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>7/11/05</i> 1905			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <i>May 6, -1860</i>	
9. AGE last birthday <i>45</i> yrs.		10. AGE last birthday <i>45</i> yrs.		11. BIRTHPLACE (State or foreign country): <i>md</i>		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>			
13. FATHER'S NAME: <i>Williams O. Harris Sr.</i>				14. MOTHER'S MAIDEN NAME: <i>May Porter</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or blank.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT & ADDRESS: <i>Mrs. Margaret C. Brady, Snow Hill, md</i>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <i>Hypertensive Cardio-Cerebro-Vascular Disease</i>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <i>7/20</i> 19 <i>55</i> , to <i>11/15</i> 19 <i>55</i> , that I last saw the deceased alive on <i>11/15</i> 19 <i>55</i> , and that death occurred at <i>4:30</i> P.M., from the causes and on the date stated above							
SIGNATURE <i>Thomas L. Jones, M.D.</i>				ADDRESS <i>Snow Hill, Md.</i>			
DATE SIGNED <i>11/17/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>7/11/05</i>			
NAME OF CEMETERY OR CREMATORY <i>Whitaker Methodist</i>				LOCATION (City, town, or county) (State) <i>Snow Hill, md</i>			
DATE RECD BY LOCAL REGISTRAR <i>Nov. 7, '55</i>				REGISTRAR'S SIGNATURE <i>Elmer C. Cooper</i>			
FUNERAL DIRECTOR <i>Wiley C. Thomas</i>				ADDRESS <i>Snow Hill, md</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

11397

CERTIFICATE OF DEATH

11402

Reg. Dist. No. 350

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL - Pocomoke</u>		<u>10</u> years		TOWN <u>RURAL - Pocomoke City</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>RFD #1</u>				<u>RFD #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
<u>Florence</u>				<u>Lankford</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>Colored</u>		<u>Widowed</u>		<u>August 23, 1898</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS			
<u>57</u> yrs.		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Corbin</u>				<u>Atline Bevans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Joe Lankford</u> <u>RFD #1, Pocomoke City, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>541.0</u> IMMEDIATE CAUSE (A) <u>Hemorrhage (Intestinal)</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Peptic Ulcer (Probably)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Refused hospitalization</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>Nov 13 1955</u>		<u>AM</u>					
22. I hereby certify that I attended the deceased from <u>Nov 13</u> 19<u>55</u>, to <u>Nov 23</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Nov 23</u> 19<u>55</u>, and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Give city, town, state)		DATE SIGNED			
<u>H. E. Sartorius</u> M.D.		<u>Pocomoke City Md</u>		<u>11/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 30, 1955</u>		<u>Hutts Chapel</u>		<u>Snow Hill, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11/30/55</u>		<u>Anne E. White</u>		<u>Henry H. Watson</u>		<u>Pocomoke, Maryland</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

JOHN A. HUNT

DECEASED

11398 **CERTIFICATE OF DEATH**Reg. Dist. No. 351

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Snow Hill</u>		<u>4 hours</u>		TOWN <u>New Church</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Goldsborough Lescealette</u>				<u>Nov 29 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>May 27, 1877</u>	<u>78</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Foreman</u>		<u>Lumber Co.</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry W. Lescealette</u>				<u>Mary Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>225-14-3076</u>		<u>Mrs Lena V. Lescealette</u> <u>New Church, Virginia</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>5 minutes</u>			
<u>442X</u> (IMMEDIATE CAUSE) (A) <u>Cerebral Accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>renal disease</u>				<u>unknown</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 22, 19 55</u> to <u>Nov 29, 19 55</u> that I last saw the deceased <u>7:30 A</u> alive on <u>Nov 29, 19 55</u> and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Paul Owen</u>				<u>Snow Hill Md</u>		<u>11/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>Dec 1, 1955</u>	<u>Groton Cemetery</u>		<u>Groton</u>		<u>Virginia</u>	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		
<u>Dec 5, 55</u>	<u>Clayton E. Cooper</u>		<u>Henry H. Watson</u>		<u>Pocomoke City, Md.</u>		

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in as a burial transit permit.

VS AISC 1-55 10A

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY		STATE		COUNTY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY		STATE		COUNTY	

BUREAU V. S.

1955

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 19

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 175C 1-55 10A

12568

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11403

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>MD.</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<i>X</i> <i>Bishop</i>		<i>Life</i>		<i>Bishop</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>00</i>				<i>rural</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Anna Parker Quillen</i>				<i>Nov. 18 1955</i>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<i>Male</i>		<i>White</i>		<i>Married</i>		<i>Mar. 10, 1892</i>	
				<i>63</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>farming</i>		<i>own farm</i>		<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William Quillen</i>				<i>Marissa Jones</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>—</i>		<i>Menie Quillen</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <i>Coronary thrombosis, sec</i>						<i>minutes</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary sclerosis & Coronary Heart Disease</i>						<i>5 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Atherosclerosis generalized</i>						<i>5 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>obesity</i>						<i>15 yrs</i>	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		<i>M.</i>					
22. I hereby certify that I attended the deceased from <i>Jan 1</i> , 19 <i>47</i> , to <i>Nov 18</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Nov 17</i> , 19 <i>55</i> , and that death occurred at <i>8:45 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Harward Robbin M.D.</i>				ADDRESS (Street, city, town, state) <i>Berlin, Md</i>		DATE SIGNED <i>Nov 18, 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>11/21/55</i>		<i>Red Men's</i>		<i>Deebysville, Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>DATE 11/19/55</i>		<i>Helen F. Hayward</i>		<i>Harry H. Watson</i>		<i>Pocomoke, Md</i>	

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 28 1955

RECEIVED